

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE				1.
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE No.		CELL PHONE No.		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE No.		CELL PHONE No.		
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS. FILL IN THE TOP BOX ALSO				

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DENTAL INSURANCE		2.
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO		
EMPLOYEE SOCIAL SECURITY NUMBER		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO		
EMPLOYEE SOCIAL SECURITY NUMBER		

ACCOUNT INFORMATION		4.
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY		STATE ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO		EXT
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO		EXT

GETTING TO KNOW YOU		3.
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY		STATE ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NO.		
ADDRESS		
CITY		STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NO.		
ADDRESS		
CITY		STATE ZIP